



CCHAT

APPLICATION FOR ASSISTANCE TO BE COMPLETED BY PARENTS OR GUARDIAN

Name of Child: _____ Date of Birth: _____
Parent/Guardian Name: _____
Mother: _____ Father: _____ Guardian: _____
Address: _____
City: _____ Zip Code: _____ County of Residence: _____
School District of Residence: _____
Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____ Email: _____

- 1) When was your child first diagnosed with a hearing loss? Give approximate dates. _____
- 2) Was your child screened for hearing loss when he/she was born at the hospital? Yes No
- 3) Did your child pass the newborn hearing screening? Yes No
- 4) What hospital was your child born? _____
- 5) Who referred you to the CCHAT Program? _____
- 6) Has your child ever worn hearing aids? Yes No
 - a. If yes, please explain: _____
- 7) Are you currently receiving services from an early intervention program for your child (speech therapy, Help Me Grow)? Yes No
- 8) Are you currently receiving services from the Regional Infant Hearing Program of Ohio? Yes No
 - a. If no, may we refer your name to the program? Yes No

Upon approval of this application from CCHAT, we agree to the following:

- a) To be fiscally responsible for the maintenance, daily care, batteries, repairs, ear molds and replacement of my child's hearing aids in the future.
- b) To return the hearing aids purchased by CCHAT to CCHAT if my child no longer needs the hearing aids. The hearing aids will be used as loaners for other children.
- c) To notify CCHAT Coordinator immediately if a change in any information occurs and/or you receive any additional information regarding your child's BCMH/Medicaid approval/denial status.

Signature of Parent/Guardian: _____ Date: _____
Signature of Parent/Guardian: _____ Date: _____

*****After completing form entirely, please save a copy as "(Patient's First and Last Name) CCHAT Application". Example: Cali Allen's CCHAT Application. Attach document in e-mail and send to: Cali.Allen@cchmc.org. If you have any questions please contact: Cali Allen at 513-636-CHAT (2428). Form can also be faxed to: 513-636-8133 ATTN: Cali Allen or mailed to: Cincinnati Children's Hospital Medical Center, ATTN: Cali Allen, 3333 Burnet Avenue, MLC 2018, Cincinnati, OH 45229-3039.*****

The Cincinnati Children's Hearing Aid Trust reserves the right to change the eligibility criteria at any time without written notification. The program will provide funding for hearing aid amplification as long as the funds for the program are available.